HEALTH FINANCE COMMISSION

Legislative Services Agency
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MEETING MINUTES[1]

Meeting Date: August 30, 2004
Meeting Time: 1:00 P.M.
Meeting Place: State House, 200 W. Washington St., House Chamber
Meeting City: Indianapolis, Indiana
Meeting Number: 2

Members Present: Rep. Charlie Brown, Chairperson; Rep. David Orentlicher; Rep. John Day; Rep. Brian Hasler; Rep. Carolene Mays; Rep. Scott Reske; Rep.Peggy Welch; Rep. Vaneta Becker; Rep. Robert Behning; Rep. Timothy Brown; Rep. Mary Kay Budak; Rep. Donald Lehe; Sen. Patricia Miller, Vice-Chairperson; Sen. Vi Simpson; Sen. Timothy Skinner; Sen. Gregory Server; Sen. Gary Dillon; Sen. Beverly Gard; Sen. Sue Landske; Sen. Marvin Riegsecker.

Members Absent: Rep. Craig Fry; Rep. David Frizzell; Sen. Billie Breaux; Sen. Connie Sipes; Sen. Connie Lawson.

Chairman Rep. Charlie Brown called the second meeting of the Health Finance Commission to order at 1:10 P.M. Information regarding the location of county hospitals in the state was distributed to the Commission as requested at the prior meeting (Exhibit A).

Generic Drug Pricing Variances (HR 59)

Ms. Alice Dodd, Milburn Pharmacy and Home Center

[1] Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.ai.org/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

Ms. Dodd introduced herself as an informed consumer from Sullivan County representing Milburn Pharmacy, an independent pharmacy. She described Sullivan County as very rural with a poor population. She commented that her employer, Milburn Pharmacy, was becoming a social service agency in the county due to all the assistance they provide to consumers in need of services. She added that middle-income individuals over age 50 appeared to be in need of assistance and that making this group eligible for Hoosier Rx would be helpful. Rural providers need to have sufficient reimbursement and a level playing field with respect to mail order pharmacies in order to survive. Ms. Dodd also noted that the Medicare drug discount cards did not appear to be as helpful as had been hoped.

Matthew Murawski, R.Ph., Ph.D., Associate Professor of Pharmacy Administration, Purdue University

Dr. Murawski described his areas of academic interest. He commented, in general, that if third-party contracts reduce the profit margin available to pharmaceutical retailers, the remaining cash payers in the market will assume more burden in making up the companies' profit margin.

Dr. Murawski reviewed the generic drug price variances reported in the northwest Indiana newspaper articles that were previously distributed to Commission members. After outlining numerous reasons for generic drug prices to vary from retailer to retailer, he concluded that newspapers try to tell a good story; they don't necessarily tell a comprehensive story. (See Exhibit B.) Next, he discussed the federal Food and Drug Administration (FDA) rating system for generic drugs. The FDA therapeutic equivalence requirements were reviewed, and the difference between therapeutic equivalence (two products that deliver the same effect) and pharmaceutical equivalence (products with the same active dosage and ingredients) was discussed.

In response to questions concerning wholesalers, distributers, and repackaging or labelers, Dr. Murawski reported that more than 75% of pharmaceutical products pass through a drug wholesaler. The wholesalers provide numerous services that might include inventory management, electronic order entry, store layout design, merchandising, and claims management, as well as numerous others. Dr. Murawski stated that the distributers and labelers constitute the "messy" part of the drug distribution system. The distributers do not manufacture their own medications. These entities make bulk purchases of drugs from generic and brand manufacturers and repackage the product into smaller units for sale. The bulk purchase and decreased packaging results in lower cost, and ultimately a lower price, to the end user. The distributers may purchase drug lots from different manufacturing plants or manufacturers, meaning that the products might look different from time to time for the consumer. Also, he stated that assessing the quality can be difficult as a result of this practice. Large pharmaceutical retail chains may have their own repackaging subsidiary or a strong relationship with one vendor.

Drug counterfeiting is not a new activity, and, as with currency, higher priced drugs are more susceptible to counterfeiting than lower cost products. Dr. Murawski stated that identification of counterfeits can be quite difficult; the patient usually destroys the evidence by taking the medication. Additionally, high priced drugs are generally associated with serious disease wherein death is a common occurrence. Consequently, counterfeit drugs may not be suspected. Dr. Murawski stated that there is reason to believe that more counterfeiting occurs than is known and that the U.S. system is considered, by far, the most secure in the world. He reviewed the requirements of the Prescription Drug Marketing Act of 1988 (PDMA). In particular, the PDMA requires states to license drug wholesalers. He reported that there appears to be variance in the degree of difficulty in obtaining drug wholesale licensure from state to state. Florida and Nevada have issued new regulations requiring criminal and civil background checks and extensive record keeping in response to incidents that have occurred.

Dr. Murawski reported that there has been some movement among states to require a "pedigree" listing a drug's history from manufacture to the final retail outlet. Wholesalers do not support this concept due to cost concerns for maintaining the paper trail. The FDA supports the concept of an electronic audit trail for the pedigree.

Dr. Murawski supplied website addresses and model rules (Exhibit C) for additional information on the subjects mentioned in his testimony.

Commission questions and discussion followed the presentation.

Certificate of Need (CON)

John Dietz, M.D., Ortho Indy

Dr. John Dietz gave a brief overview of the Certificate of Need issue. It was developed as a result of a GAO survey. The intent of the program was to limit capital investment in order to control access and the resulting cost in the health care system. He stated that Certificate of Need did not work when first implemented and will not now. Dr. Dietz commented that CON can be expected to stifle competition and that competition will ultimately lower healthcare costs. He further stated his belief that physician ownership aligns the incentive to keep costs low and improve the quality of the services provided. Dr. Dietz added that outcome data was needed to allow for assessment of the quality of patient care.

Commission questions and discussion followed concerning the perceived practice of "cherry-picking", who should pay for uncompensated care provided at community hospitals, transfer agreements for patient complications, and whether a building moratorium should be implemented.

Jim Leich, Indiana Association of Homes and Services for the Aging

Mr. Leich stated that nursing facilities had delicensed beds in order to meet the Medicaid capacity reimbursement rules and that nursing home use continues to decline. He added, however, that there are still too many beds and that the closure of facilities, not delicensing beds, would save cost in the long-term care system. Mr. Leich stated that new facilities were providing more amenities in smaller facilities and that assisted living and home and community-based services were competing with the nursing facilities for patients. He added that the federal review of the quality assessment fee appeared to be nearing approval. He specifically stated that a certificate of need application program was undesirable. He added that a moratorium was less objectionable, but existing providers would be locked into place under a moratorium. Mr. Leich suggested that any moratorium should include exemptions for facilities with very high occupancy rates and for horizontally integrated facilities. He concluded his remarks by stating that much of the nursing facility infrastructure is aging, and financing for reconstruction and replacement will be necessary.

Steve Albrecht, Indiana Health Care Association

Mr. Albrecht commented that the system needs to limit growth, reduce expenditures, and improve the quality of care. He stated that CON did not limit the number of beds opened and operated when it was in place in Indiana. In his opinion, Medicaid reimbursement changes introduced more efficiency and competition, citing a decrease in the number of Medicaid-certified, long-term care facilities and beds between the years 2000 and 2004. In addition, he thought that home and community-based care offers competition for nursing home patients. With regard to quality of care, Mr. Albrecht stated that nationally, Indiana nursing facilities are ranked very high in state survey results.

Commission discussion followed with questions regarding the need for long-term care beds in the future as the impact of aging baby boomers affects the need for long-term care. Additional questions focused on specialty Alzheimer's units. Mr. Albrecht commented that while the number of specialty units was increasing, the number of care givers necessary to provide services for this population is not available to meet the demand.

Zach Cattell, Indiana State Department of Health

Mr. Cattell commented that when the Indiana Department of Health operated the CON program, they did not have adequate staff or expertise available. The Department did not have the technical ability to determine need for health care facilities and services. The requirements for acute care and long-term care differed with regard to resources needed. Mr. Cattell said that the Department did not agree with the concept of a moratorium with any exceptions for long-term care facilities. With regard to a CON program affecting the acute care system, he commented that the staffing requirements would be significant if the program were to be effective. He cited Michigan's CON program, which operates with 12 to 14 staff members and has a budget in the millions of dollars. Mr. Cattell said that the Department has no position regarding niche providers that are not currently regulated.

Commission discussion followed regarding specialty service providers that are not licensed and potential reporting requirements.

Bob Decker, Hoosier Owners and Providers for the Elderly (HOPE)

Mr. Decker stated that he had not seen any benefits of increased competition; as an employer, health insurance premiums continue to increase in cost. He also commented that the implementation of the quality assessment fee might cause a shift in the number of long-term care beds. Mr. Decker supported the concept of a moratorium on new construction and conversion projects, but not on replacement facilities. In his opinion, a moratorium would produce quick results, allow for quick implementation, and would be most fair to all players. Mr. Decker commented that the state needed to limit the number of long-term care providers, pay a fair price to providers, and monitor the quality of the services they provide.

David Hale, United Auto Workers (UAW)

Mr. Hale stated that the UAW supports the reinstatement of CON. He said that the high cost of health care due to excess capacity leads to the loss of jobs in the state. He cited statistics for the cost of capital expansion (currently estimated to be about $2.7 B for planned projects throughout the state) and market saturation (Kokomo has 5 Magnetic Resonance Imaging scanners (MRIs), and two hospitals when he believes that only one is needed). Mr. Hale urged the Commission to support CON legislation because it can affect cost. CON, he commented, will prevent unnecessary capital expansion and help hold down costs in the future.

There was discussion among the Commission members regarding what categories should be controlled by CON; buildings, numbers of beds, equipment, and specialty services were mentioned. Chairman Brown observed that a Federal Trade Commission (FTC) report had recommended the elimination of CON.

Russ Towner, DaimlerChrysler and the Alliance of Automobile Manufacturers

Mr. Towner observed that health care costs for employers continue to escalate. Mr. Towner offered comparison statistics from the DaimlerChrysler healthcare plan across the several states in which the corporation operates. He stated that while the Indiana employee group covered under the plan was, on average younger and had similar health status, health care cost

in Indiana was 30% higher than under the same plan in Michigan.
He added that a focus on quality improvement and patient outcomes was needed. Mr. Towner said that CON will put accountability and planning back into the Indiana health care equation. He added that the FTC report that recommended the elimination of CON also recommended the repeal of "any willing provider" provisions and self-referrals, among other actions.

Commission questions followed with regard to the comparability of the statistics cited and the interpretation of those statistics.

Carol Blanar, Indiana Federation of Ambulatory Surgery Centers

Ms. Blanar stated that the Indiana Federation of Ambulatory Surgery Centers opposed CON. She attributed increased costs in the system to increasing costs of pharmaceuticals and hospital care. She said that competition is vital to keeping costs down. Ms. Blanar recommended further study of this problem.

Richard Fogle, M.D., The Care Group, Heart Center of Indiana

Dr. Fogle, a cardiologist with the Heart Center of Indiana, described the organization as a specialty care provider developed as a joint venture with St. Vincent Hospital. Lack of physical capacity at St. Vincent led to the development of the facility, which is owned 50/50 by St. Vincent and the 120-member Care Group. Dr. Fogle stated that the Heart Center of Indiana operates with the same charity and indigent care policies as used by St. Vincent Hospital. He said that patients are accepted regardless of their ability to pay. Dr. Fogle stated that the focus of the Heart Center was on high quality care, patient satisfaction, and quality outcomes, as well as local medical training with an emphasis on best practices. In Dr. Fogle's opinion, competition for services at the disease-specific level with disclosure of outcomes will result in overall better patient care. (See Exhibit D.)

Commission questions and discussion followed regarding the fact that Medicare reimbursements do not reward quality outcomes and comments on "any willing provider" provisions.

Charles Hiltunen, Midwest Eye Institute, Beltway Surgery Centers

Mr. Hiltunen commented that the Commission had requested data regarding CON programs in other states. He distributed three exhibits in response to that request. (See Exhibits E, F, & G.) He stated that CON should be opposed on the basis that free and competitive markets allocate resources better than government regulations. He added that evidence indicates that state CON programs tend to be captured by the dominant hospitals they were intended to regulate. He suggested that alternative policies to strengthen competition and examine clinical outcome data would be valuable. In addition, state health care status indicators show a need to focus on increased health education.

Mr. Hilltunen urged the Commission to consider the impact that implementing CON might have on state economic initiatives directed at biotechnology and life sciences industry growth. He pointed out that there is a relationship between medical education, biotechnology, and large specialty hospitals where clinical trials are performed.

Tim Kennedy, Indiana Hospital and Health Association (IHHA)

Mr. Kennedy responded to questions raised at the previous meeting regarding the IHHA position on CON legislation. He reported that the association does not yet have an official position. He offered four discussion points: (1) With regard to CON, the hospitals have

conflicting opinions depending upon their respective market positions; (2) Prohibiting doctors from referring to entities in which they have an ownership interest may be a hardship for small towns with limited numbers of providers; (3) Consideration of an assessment to pay for uncompensated care based on a benchmark standard for an appropriate level of indigent care; and (4) Methods of leveling the playing field, including such options as requiring niche providers to be licensed if they are not currently required to do so, requiring data reporting standards for specialty providers that are similar to those imposed on hospitals, and requiring similar construction standards for niche providers as those required for licensed hospitals.

Commission discussion followed regarding the lack of unbiased, hard data available on which to base decisions. The members discussed the concept of a special blue ribbon committee.

The next meeting of the Commission was scheduled for September 29, 2004, at 1:00 P.M.

The meeting was adjourned at 4:20 P.M.